Executive Summary

ES.1 Introduction

One of the key objectives of the Medicare Fee-for-Service (MFFS) national implementation of the Consumer Assessment of Health Plans Study (CAHPS®) is to provide information to help beneficiaries decide among health plan options. Currently, through surveys of both the Medicare Managed Care (MMC) enrolled population and the beneficiaries on original Medicare, beneficiaries residing in areas in which there is a choice of plans are able to access data comparing CAHPS measures for MMC and MFFS. In this report, we compare and provide results of analyses of data from the second year of the national implementation of the MFFS CAHPS survey (the complete 2001 CAHPS Medicare Satisfaction Survey instrument is included in Appendix A). This also marks the first year in which comparisons can be made between our findings from the 2000 survey (Final Report for Year 1), and our findings from the 2001 survey.

We performed these analyses to gain a better understanding of the differences in health services experience and satisfaction among subgroups of Medicare beneficiaries including geographic levels (national, regional, and state level), sociodemographics, health plan options, and health status. The MFFS population, enrolled in what is also known as the Original Medicare Plan, is quite heterogeneous in terms of demographic characteristics, region of residence, supplemental insurance (whether with or without prescription drug coverage or Medicaid), and health-related characteristics. These subgroups of the MFFS beneficiaries have vastly different experiences with and expectations of the health care system and thus may perceive the quality of and access to services differently.

The goals for the data generated by the CAHPS Medicare Satisfaction Surveys include its use for quality improvement, accountability, and beneficiary information. Achievement of these goals require that data be reported on a number of levels of aggregation, including geographic sampling unit, state, region, and nation. In markets where there are plans that offer choices to beneficiaries, the aggregation enables comparison of MFFS and MMC. By examining regional, state, and national variation in CAHPS ratings and composites among Medicare beneficiaries by subgroup and individual characteristics, the Centers for Medicare & Medicaid Services (CMS) are better able to understand beneficiary experience with the health care system and the performance of different plan options.

This report highlights variations in ratings and composites across geographic levels, among subgroups of beneficiaries within the MFFS plan at the regional and individual levels, and among beneficiaries enrolled in MFFS and MMC by plan option and health status. In Section I we focus on the MFFS plan. In Chapter 1, "Descriptive Analysis," we report the results of descriptive data analysis, including frequency distributions and cross-tabulations by sociodemographics, health status, insurance and other variables (e.g., MMC penetration rates, urban/rural and having a personal doctor). In Chapter 2, "Multivariate Analysis," we examine

differences among subgroups of Medicare beneficiaries at the individual level to understand differences in health services experience and satisfaction by characteristics of subgroups within the MFFS population. By holding other factors constant in the multivariate analyses and by stratifying according to certain characteristics, we can better understand disparities among subpopulations. In Chapter 3, "Geographic Variation in Ratings and Composites by Subgroups of MFFS Beneficiaries," we summarize key findings and discuss variations in performance indicators aggregated to different geographic levels and stratified by a number of beneficiary subgroups, including self-reported health status, insurance, and demographic characteristics. Results on the geo-unit level for both 2000 and 2001 are presented in Appendix D. Finally, Section II focuses on comparisons between MFFS and MMC; in Chapter 4, "Medicare Fee-for-Service and Medicare Managed Care: Differences in Plan Ratings and Composites," we provide the results of our analysis of the MFFS and the MMC comparisons.

ES.2 Case-Mix Adjustment

CMS is required by the 1997 Balanced Budget Act (BBA) to provide beneficiaries with information that will enable them to choose between Medicare plan options. This requirement necessitates the construction of CAHPS ratings and composites that can be compared across managed care plans and between managed care and fee-for-service options. The implication for the construction of the composites from the MFFS survey is that they be created in as like a manner as possible to those from the MMC survey.

Because CMS intends to provide quality information to support Medicare beneficiaries' choice of Medicare health plan options, it is essential that differences between the composition of Medicare beneficiaries in FFS and in managed care be adequately adjusted for when data are reported. For MFFS, this adjustment must be made on the reporting-unit level and, in order to allow like comparisons, must be comparable in rigor and scope to the adjustment made on the MMC sample. Case-mix adjusted consumer ratings can provide more valid health plan comparisons than can unadjusted ratings by controlling for factors related to systematic response biases for questions about experience obtaining health care services. Adjusted data are therefore potentially more appropriate for comparing the quality of care delivered. Case-mix adjustment for systematic bias is useful when comparing assessments of different plans or regions if members of a particular demographic group that is more or less inclined than others to assign poor ratings to bad care are disproportionally enrolled in a particular plan or, as in the case of within-MFFS comparisons, these members reside in a particular geographic area. In many markets, MFFS beneficiaries tend to be older and more frail than MMC beneficiaries. In order to present fair comparisons, the influence of plan composition must be accounted for in the reporting statistic. A similar argument can be made for comparison of ratings and composites for different geographic units within the MFFS population. For these reasons, all ratings and composites used to compare MFFS and MMC, or regions within the MFFS population, are case-mix adjusted.

ES.3 Beneficiaries with Plan Choice

Comparisons of health care satisfaction between MFFS and MMC beneficiaries must be considered in the context of accessibility to Medicare + Choice (M+C) plans. Estimates generated from the 2001 MFFS and MMC Satisfaction Surveys indicate that 58.8% (+/-0.2%) of the 30.1 million Medicare FFS beneficiaries eligible for the 2001 MFFS survey lived in a county that had at least one M+C plan. The availability of M+C plans varied considerably by state, region of country, and beneficiaries' proximity to a major urban area. Medicare FFS beneficiaries in seven states and Puerto Rico had no access to M+C plans at all, while statewide access was available in only three states (Hawaii, New Jersey, and Delaware). Regionally, access to M+C plans ranged from a low of 35.4% for MFFS beneficiaries in CMS Region 8, the Denver Regional Office, to a high of 85.0% for those in CMS Region 9, the San Francisco Regional Office.

Proximity to a major urban area was the most significant factor in the availability of M+C plans for MFFS beneficiaries. In 2001, 75.5% (+/-0.3%) of Medicare FFS beneficiaries living in Metropolitan Statistical Areas (MSAs) had access to M+C plans. This compares to 25.1% (+/-08%) of MFFS beneficiaries living in counties adjacent to MSAs and only 10.1% (+/-0.6%) of MFFS beneficiaries living in counties not adjacent to MSAs. Clearly, the comparisons of MFFS and MMC presented in this report need to be tempered with the geographic realities of Medicare beneficiaries' access to M+C plans. Because of the variation in availability of an M+C plan, ratings and composites used for MFFS and MMC were weighted to include the subset of the MFFS group who reside in an area with plan choice.

ES.4 Performance Indicators

The analyses presented in this report examine differences across selected data aggregation options for the most-positive CAHPS ratings and responses (i.e., "10," "Always," "Not a Problem," or "Yes"). A total of nine performance indicators (five composite indicators and four rating indicators) were used from the 2001 CAHPS Medicare Satisfaction Survey. The complete survey may be found in Appendix A.

- ***Needed Care Composite***
- ***Good Communication Composite***
- ***Care Quickly Composite***
- ***Respectful Treatment Composite***
- ***Medicare Customer Service Composite***
- ***Rate Personal Doctor***
- ***Rate Specialist***
- ***Rate Health Care***
- ***Rate Medicare***

ES.5 Key Findings for Subgroups with the MFFS Population: Descriptive and Multivariate Analyses

Findings from our descriptive analyses suggest that there are differences in satisfaction and experience associated with sociodemographic characteristics, health status, and insurance type. In general, beneficiaries who gave a higher percentage of most-positive responses were older, female, with less education. We found an inconsistent pattern of responses by race and ethnicity; Hispanics gave a lower percentage of most-positive responses for about half of the questions comprising the composites, but a higher percentage of most-positive responses for all of the ratings. Black beneficiaries gave a higher percentage of most-positive responses for all of the questions that make up the Good Communication Composite, but the lowest percentage of most-positive responses regarding getting needed care without delays. Beneficiaries of other race provided a lower percentage of most-positive responses for just over half of the questions comprising the composites, including all questions regarding getting care quickly.

In the multivariate analysis, we examine the ratings and the questions comprising the composites that are reported on the Medicare Health Plan Compare web site. In general, beneficiaries who were more satisfied and reported better experiences were older, healthier, less educated, black, Hispanic, or female.

The association between insurance and ratings and composites was inconsistent. While we would expect that beneficiaries with insurance in addition to Medicare, particularly those with prescription drug coverage, would report higher ratings for obtaining needed care or obtaining care quickly, this was not always the case. Beneficiaries who report having no additional insurance, are dually eligible, or did not provide insurance information were more satisfied and reported better experiences than those with additional insurance and prescription drug coverage for two of the three composites (good communication, getting care quickly), and both ratings. However, these same groups were less satisfied and reported worse experiences getting needed care compared with beneficiaries who had additional insurance and prescription drug coverage. Beneficiaries who had additional insurance but no prescription drug benefits were less satisfied and reported worse experiences than those with additional insurance and prescription drug benefits.

Beneficiaries living in areas with up to 25% MMC penetration were more satisfied and reported better experiences than those living in areas with greater than 25% MMC penetration. Beneficiaries living in urban areas were less satisfied and reported worse experiences with their health care than those living in rural areas. Finally, beneficiaries with no personal doctor or nurse were less satisfied and reported worse experiences than those who reported having a personal doctor or nurse.

Overall, our findings related to age, education, gender, health status, having a personal doctor or nurse, and living in an urban versus rural area are consistent with results from the Year 1 Final Report (Bernard et al., 2001). However, our findings related to MMC penetration are not

consistent with results from our Year 1 analysis which found that beneficiaries living in areas with lower MMC penetration (< 25%) were less satisfied, reported more problems, and assigned lower ratings than beneficiaries living in areas with higher MMC penetration. Similar to last year, we found statistically significant differences in satisfaction and experience by type of insurance. Some of the findings are consistent across both years, but others are not.

ES.6 Regional and State Variations in Ratings and Composites by Subgroups of MFFS

We examined differences among subgroups of Medicare beneficiaries by CMS region and by state (including Puerto Rico and the District of Columbia) to understand geographic variation in health services experience and satisfaction by characteristics of subgroups within the MFFS population. By holding other factors constant in the multivariate analyses and by stratifying according to characteristics such as illness, recent hospitalization, and access to additional insurance, CMS can better understand subpopulation differences in a particular region or state.

Analysis was performed across various data aggregation options, such as the nation, CMS region, and state, for the most-positive CAHPS ratings and responses. When ratings and composites are aggregated to state, regional, and national levels, the percent differences are still present but mitigated.

Key Findings

- When the education data are aggregated to the CMS region and the national level it is apparent that MFFS beneficiaries with less than high school education or general equivalency diploma report more positive perceptions of their health care than those with more education.
- A higher proportion of Hispanic beneficiaries than non-Hispanics gave a rating of "10" across the indicators. Black beneficiaries responded more favorably than white beneficiaries or those of other races on six of the nine indicators nationally.
- Generally, a lower percentage of chronically ill beneficiaries responded most positively to all of the indicators compared with beneficiaries who are not chronically ill.
- On the national level, a similar percentage of Medicare beneficiaries indicated that they always receive needed care in 2001 than in 2000 (89% vs. 87%). The percentage of beneficiaries assigning a "10" for Rate Medicare (46%), Rate Health Care (49%), Rate Specialist (48%), and Rate Personal Doctor (50%), were all within 1 to 2 percentage points of what they were in 2000 (e.g., 2–6%).
- MFFS beneficiaries in the Seattle CMS region had the lowest percentage of positive responses for five indicators: the Good Communication Composite, the Medicare Customer Service Composite, Rate Personal Doctor, Rate Health Care, and Rate Medicare (in 2000, Denver had the lowest percentage of most-positive responses for four indicators). In contrast, the Dallas CMS region had the highest percentage of positive responses for four performance indicators: the Good Communication Composite, the Care Quickly Composite; and Rate Specialist, Rate Health Care, and Rate Medicare.

- ➤ Across all geographic levels, the Needed Care Composite consistently garnered the highest percentages of most-positive responses, and the Rate Medicare indicator had the lowest percentages of most-positive responses. These findings are consistent with those of 2000.
- ➤ Perceptions of satisfaction and experience with Medicare differ among subgroups of beneficiaries. In 2000, variations in composites and ratings were found for insurance status (dually eligible and with versus without insurance in addition to Medicare), self-reported health status, race, gender, and age. In 2001, more variables were examined and differences were found by all of them.

Conclusions

Compared with other indicators, fewer Medicare beneficiaries give the highest rating to their overall Medicare experience (Rate Medicare indicator) and there is substantial variation across state and regional geographic areas for this indicator. Notable differences across states (including the District of Columbia and Puerto Rico) and regions also exist for personal doctor ratings (Rate Personal Doctor), specialist ratings (Rate Specialist), and the Medicare Customer Service Composite. These findings are consistent with those reported in Chapters 1 and 2 on the individual level, but persist even when the data are aggregated up to the state, CMS region, and nation. In particular, the following subgroups reported lower levels of satisfaction: younger beneficiaries (especially beneficiaries under 46 years), beneficiaries with more than a high school education, men, those who are less healthy (fair/poor self-reported health, chronically ill, hospitalized overnight in the last year), and those without a personal doctor.

Findings were mixed for some of the other subgroups with members reporting positive experiences and high levels of satisfaction for some of the indicators, but negative experiences and dissatisfaction for other indicators. For example, Hispanics reported worse experiences than non-Hispanics on the Needed Care, Care Quickly, and Respectful Treatment Composites. However, non-Hispanics were less satisfied than Hispanics as they gave a lower percentage of "10s" for all four ratings. Findings were also mixed for race with white beneficiaries reporting worse experiences than blacks for six of nine indicators. Finally, there were also mixed findings for those with different types of supplemental insurance. For example, beneficiaries who have additional insurance without prescription drug coverage provided a lower percentage of most-positive responses for Good Communication, Respectful Treatment, and all four ratings. On the other hand, dually eligible beneficiaries provided the lowest percentage of most-positive responses for the Needed Care and Care Quickly Composites.

ES.7 Medicare Fee-For-Service and Medicare Managed Care: Differences in Plan Ratings and Composites

We describe the results of our analysis of the MFFS and MMC comparisons, and examine differences in ratings and composites by plan option (MFFS versus MMC) and by health status. In the latter analysis, we addressed the question of whether beneficiaries in poor/fair

health or excellent/very good health rate their experience with Medicare differently if they are enrolled in MFFS or MMC by pooling data from the 2000 and 2001 surveys.[1]

We compared MFFS and MMC in 44 states[2] and the District of Columbia on the six ratings or composites that are reported on the Medicare Compare web site. To further ensure consistency with the Medicare Compare web site, most comparisons throughout this report and, more specifically, comparisons between MFFS and MMC, are based on extreme positive response categories. The ratings and composites listed below were used in the analyses in Chapter 4.

- ***Needed Care Composite***
- ***Good Communication Composite***
- ***Care Quickly Composite***
- ***Rate Health Care***
- ***Rate Medicare***
- ***Flu Shot indicator***

Key Findings

- On the national level, the percentage of beneficiaries providing the most-positive response decreased slightly from 2000 to 2001. There were only two instances when the percentage of beneficiaries who gave the most-positive response was higher in 2001 than it was in 2000: among MFFS beneficiaries for the Needed Care Composite and among MMC beneficiaries for the Care Quickly Composite.
- For the most part, at least half of the states that were ranked in the top 10 or bottom 10 by the percentage of most-positive responses in 2000 remained in the top or bottom 10 in 2001.
- On the national level in 2001, MFFS beneficiaries gave significantly higher percentages of the most-positive response for the Needed Care Composite, Rate Plan a 10, and Rate Health Care a 10. In 2000, MFFS beneficiaries gave a higher percentage of most-positive responses for Needed Care, Rate Plan a 10, and slightly higher for Care Quickly.
- On the national level, using data pooled from 2000 and 2001, a lower percentage of beneficiaries in fair/poor health responded most positively compared with beneficiaries in excellent/very good health, except for the flu shot indicator.
- Among beneficiaries in excellent/very good health, a higher percentage of MMC beneficiaries responded most positively for all but the Needed Care Composite. State differences tended to be consistent with national results.
- Among beneficiaries in poor/fair health, a higher percentage of MMC beneficiaries responded most positively for four of six indicators. State differences tended to be consistent with the national results.

[1]In addition to conducting the analysis using the pooled dataset, we also conducted the analysis of only the Year 2 data using the Year 2 case mix model and again using the Year 1 case mix model. The results from both analyses were largely unchanged.

[2]Forty-four states have MMC penetration enabling us to make comparisons between MFFS and MMC.

Conclusions

While we cannot know with any certainty the cause for the drop in experience or satisfaction with health care services in 2001 compared with 2000, we do know that beneficiaries in 2001 had slightly lower most-positive responses than beneficiaries in 2000. However, there seems to be a stability in the pattern of responses; overall, at least half of the states that were ranked in the top or bottom 10 by the percentage of most-positive responses in 2000 remained in the top or bottom 10 in 2001. However, there appears to be more movement in and out of the top and bottom 10 in MFFS as compared with MMC.

On the national level, MMC performed better than MFFS on four of the six indicators in 2001 compared with three of the six indicators in 2000.

A consistent finding emerged from our analysis of the 2000 and 2001 pooled survey data across MFFS and MMC is that a lower percentage of beneficiaries in fair/poor health responded most positively compared with beneficiaries in excellent/very good health for the Needed Care Composite, Good Communication Composite, Care Quickly Composite, and Rate Health Care. This was also the case for Rate Medicare with the exception of four states. However, the opposite pattern occurs for the flu shot indicator with a higher percentage of beneficiaries in fair/poor health reported receiving a flu shot. This is likely because beneficiaries in fair/poor health often have more doctor office visits and probably received their flu shot while at one of their doctor appointments or that physicians are more aggressive at recommending the shots for those in poorer health. Furthermore, it is possible that beneficiaries in fair/poor health elect to receive a flu shot more often than those in excellent/very good health because they feel more vulnerable to catching the flu.

Nationally, significantly higher percentages of MMC beneficiaries who reported excellent/very good health provided responses of "10," "Always," "Not a problem," or "Yes" for five of the six indicators compared with MFFS beneficiaries: Good Communication, Rate Health Care, Rate Medicare, Care Quickly, and Flu Shot. Across the six indicators, in states where there were significant differences between MFFS and MMC beneficiaries in excellent/very good health, the differences tended to be consistent with the national results.

We also found significant differences in the effects of plan type among beneficiaries in poor/fair health. Nationally, significantly higher percentages of MMC beneficiaries in poor/fair health provided the most-positive responses for four of the six indicators: Good Communication, Care Quickly, Rate Health Care, and Flu Shot. In states where significant differences existed between MFFS and MMC, results tended to be consistent with the national results.